Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Form 7.30

Name of Practice: 125 Sellersville - Vision Innovation Centers of PA - BMEA

Patient Name: ______________________________

Social Security Number: ____________________ **Date of Birth:** ____________

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

____

Name of Personal Representative Phone

____

Address

____

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

125 Sellersville - Vision Innovation Centers of PA - BMEA

____

____

Attn: Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

______________________________ ____________

patient signature date

Copies of signed authorizations are available upon request.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I am a patient at Vision Innovation Centers of PA. I hereby acknowledge receipt of

Chesapeake Eye Care Managements' Notice of Privacy Practices.

Name [please print]: ______________________________

Signature: ______________________________

Date: ______________

OR

I am a parent or legal guardian of ______________ [patient name]. I hereby

acknowledge receipt of Chesapeake Eye Care Management's Notice of Privacy Practices

with respect to the patient.

Name [please print]: ______________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ______________________________

Date: ______________

Financial Policy

Thank you for choosing a Chesapeake Eye Care Management provider. We are committed to providing you with quality and affordable health care. We realize that the cost of healthcare is a concern for our patients, and we are available to discuss our professional fees at any time. The following is a statement of our Financial Policy, which you must read, agree to and sign prior to treatment. Carefully review the information and please ask if you have any questions about our fees, policies or your responsibilities.

PATIENTS WITH INSURANCE: Valid health insurance information must be provided to ensure appropriate reimbursement for your care. We ask that you present your insurance card at every visit. Patients are responsible for any pertinent deductibles, co-payments, "noncovered" services resulting from the insurance claim processing. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES: Co-payments are due at the time services are rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is a direct violation of our contract with the insurance provider. If you unable to pay your co-payment today, your appointment will be re-scheduled.

MEDICARE PATIENTS: We will file to Medicare on your behalf, and with valid and effective secondary/tertiary coverage will also forward claims directly. Patients will be responsible for any resulting coinsurance and deductibles not covered by your additional (secondary/tertiary) insurance. Patients are responsible for non-covered services/supplies under separate notice (referred to as an ABN).

REFERRALS: Valid referrals and authorizations, as required by your insurance (including worker's compensation carriers), must be received before services are rendered. If the referral form is not obtained, and my insurance company denies the claim due to this, I will be responsible for payment in full for services rendered.

WORKER'S COMPENSATION and MOTOR VEHICLE ACCIDENT: We will file a claim to W/C carriers and/or auto claims with valid information. You must obtain a claim number, phone number, contact person and name and address of the insurance carrier PRIOR to your visit. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

SELF PAY: Self pay accounts are patients without insurance coverage. You are responsible for paying 100% of the charges at the time services are rendered.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

STATEMENTS: A statement will be sent to you once it becomes patient responsibility. It is our practice to bill patients once a month. If you wish to dispute the validity of the balance, we ask that you contact us immediately. Failure to make a timely payment will result in further collection action which could include accrued interest and attorney's fees.

COLLECTION OF OUTSTANDING BALANCES: All outstanding balances will be addressed at a patient's follow-up appointment. We do ask that any outstanding balances are taken care of at that time unless discussed with either the Billing Manager or the Collections Specialist.

FORMS COMPLETION: We do charge for completion of any forms that need to be completed by the physician. The fee will be discussed when the form is presented to the Front Desk.

CONTACT LENSES: By signing this document you are agreeing to be responsible for the overall cost of your lenses. Your lenses must be paid in full at the time of pick up, unless discussed and approved otherwise by the prescribing doctor, and the billing department of Chesapeake Eye Care Management. If using your insurance, please be aware that if your insurance denies any coverage for your contact lenses, you will be held responsible for the remaining balance.

PAYMENT METHODS: We accept payment by cash, check, Mastercard, Visa, Discover, American Express and CareCredit. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private health information for the purpose of treatment and re-imbursement for such care. In addition, I hereby authorize and assign benefits directly to Vision Innovation Centers of PA, LLC. I have read and understand the above described Practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

Patient Authorization

I authorize Chesapeake Eye Care Management Affiliate to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.

I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided, when a statement is rendered.

I understand I will be responsible for any collection fees if my account is delinquent and referred to an attorney for collection purposes. Attorney's fees of 15% will be charged in addition to principal balance of the account if referred to an attorney for collection purposes. Delinquent accounts accrue interest at the rate of 1.5% per month Ver. Date. 03.25.2019

Patient's name DOB

Signature Date

Notice To All Patients

With the increasing complexity of insurance billing, we are finding often there is confusion around medical and routine insurance coverage. Routine coverage is typical for non-medical eye exams and medical insurance addresses medical related problems. Due to these misconceptions we are asking that you inform us of all insurance lines of coverage and your intentions for the visit today. We will not change a diagnosis after it has been submitted to your insurance company. We cannot be expected to know the insurance coverage of every patient and we do not base our diagnosis on the patient's insurance coverage.

To prevent erroneous denials and to help you collect from your insurance on the first filing of the claim, please clearly indicate during your exam today which insurance you are wishing to file to. In the event the exam is medically indicated, it may be necessary to change the insurance coverage to your medical plan. This is based on medical diagnosis, testing and decision making and should be reviewed with you by your provider. If you have a concern regarding the doctor's diagnosis, please verify it upon checkout after your visit.

If you are using Routine Insurance and the physician finds a medical diagnosis, your Medical Insurance will be billed, and you may have an out of pocket expense.

Please sign below to acknowledge your understanding.

____

Signature Date

Medical Exam Refraction and Dilation Consent

A refraction is a test that is performed during your eye exam using a phoropter. Most people that have had an eye examination remember the refraction as the part of the examination in which the doctor or technician asks, "Which lens is clearer or better -- lens one or lens two, or do they appear about the same?

This test is a necessary part of an ophthalmic examination to help determine your best possible visual acuity and to aid the physician in determining if there is a medical reason causing your symptoms. With this test we determine whether you can be helped in any way by a new glasses prescription and the only way a new prescription can be written. This exam also indicates if any medical, optical or surgical treatment may be needed.

Most major insurance companies do not cover charges for a refraction. Medicare is one company that does not pay for this service. The fee for refraction is collected at time of service along with any co-payments, co-insurance, and/or deductibles your plan require. These amounts are to be paid in full at the completion of your visit.

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and inability to see well at close range for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patient should wear sunglasses, be cautious when walking and going up or down stairs. It is recommended that you consider bringing a driver in the effect the dilation effects are bothersome while driving.

____

Patient's name DOB

____

Signature Date

Bucks-Mont Eye Associates

PATIENT REGISTRATION

□ Miss □ Mrs. □ Ms. □ Mr. □ Dr.

PATIENT: ______________________________ BIRTH DATE: ____________

Last Name First Name Middle

ADDRESS: ______________________________

Street Apt/Box City State Zip Code

HOME PHONE: ____________ WORK PHONE: ____________

CELL PHONE: ____________ EMAIL ADDRESS: ____________

SOCIAL SECURITY #: ____________ SEX: □ Female □ Male

RACE: ____________ LANGUAGE: ____________ ETHNICITY: □ Hispanic □ Non-Hispanic

STATUS: □ Single □ Married □ Widowed □ Separated □ Divorced

EMPLOYER: ____________ OCCUPATION: ____________

HOW WERE YOU REFERRED TO US? ____________

PHYSICIAN INFORMATION (ADDRESS AND PHONE NUMBERS ARE VERY HELPFUL)

REFERRING PHYSICIAN: ____________ PHONE: ____________

ADDRESS: ____________

PRIMARY CARE PHYSICIAN: ____________ PHONE: ____________

ADDRESS: ____________

OTHER PHYSICIAN'S NAME: ____________ PHONE: ____________

ADDRESS: ____________

INSURANCE INFORMATION

Responsible Party if other than patient: ____________ RELATIONSHIP: ____________

Address if different from patient: ____________

Street Apt/Box City State Zip Code

Primary Insurance: ____________ Subscriber: ____________ DOB: ____________

ID#: ____________ Group ID#: ____________ Relationship to Subscriber: □ Self □ Spouse □ Child

Secondary Insurance: ____________ Subscriber: ____________ DOB: ____________

ID#: ____________ Group ID#: ____________ Relationship to Subscriber: □ Self □ Spouse □ Child

IF INJURED: PLACE INJURY OCCURRED: □ Home or School □ Work □ Auto Accident

Date of Injury: ____________ Contact Person: ____________ Phone: ____________

Assignment and Release: I hereby authorize my insurance and government benefits to be paid directly to Bucks-Mont Eye Associates. I am financially responsible for any balance due because of co-pay, deductible, referral/authorization not obtained prior to visit or incorrect insurance information. I agree to the terms of the BMEA financial policy. The policy has been posted and a copy is available upon request.

SIGNED: **X** ______________________________ DATE: ____________

MEDICAL HISTORY QUESTIONNAIRE

BUCKS-MONT EYE ASSOCIATES
711 Lawn Avenue • Sellersville, PA 18960
P 215-257-8053 • F 215-257-2020

Name: **Date of Birth:** **Date:**

Referring Doctor: ______________________ **Phone:** ____________
Family Doctor: ______________________ **Phone:** ____________
Specialists: ______________________

Review of Symptoms of Current Health Issues: **(Please circle all that apply)**

EYES: **Circle which eye**

Blurred Vision: Right Left **Eye Pain:** Right Left **Floaters:** Right Left
Loss of Vision: Right Left **Flashes of Light:** Right Left **Shadows:** Right Left
Distortion or Wavy Vision: Right Left **Glare:** Right Left
Do you currently wear glasses? Yes No **How old are your present pair?** ____________
Do you currently wear contact lenses? Yes No **Type of contact lenses:** ____________

Do you CURRENTLY have any problems in the following areas?	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL: (headaches, fatigue, fever, insomnia, weight loss, weight gain, unusually tired, heat stroke)			
EARS / NOSE / THROAT: (hearing loss, stuffy nose, ear ache, cough, dry mouth, hoarseness, vertigo, etc.)			
CARDIOVASCULAR: (chest pain, high blood pressure, irregular heartbeat, palpitations, etc.)			
RESPIRATORY: (asthma, shortness of breath, sputum, TB Exposure, wheezing, etc.)			
GASTROINTESTINAL: (stomach upset, diarrhea, constipation, hernia, ulcers, nausea, vomiting, reflux, ulcer, etc.)			
GENITOURINARY: (painful urination, frequent urination, kidney stones, blood in urine, impotence, yellow jaundice, etc.)			
REPRODUCTIVE: Females: Are you Pregnant? Are you Nursing?			
MUSCULOSKELETAL: (arthritis, back pain, bone/joint pain, stiffness, swelling, cramps, etc.)			
DERMATOLOGIC: (acne, warts, growths, rash, etc.)			
NEURO/PSYCHIATRIC: (numbness, seizures, paralysis, Alzheimer's, anxiety, depression, dementia, Parkinson's, memory loss, etc.)			
METABOLIC/ENDOCRINE: (Diabetes, hypothyroid, hyperthyroid, increased thirst, increased urination, kidney failure, kidney removal, etc.)			
HEMATOLOGY: (bleeding, anemia, problems related to blood transfusion, bruises easily, blood clots, high cholesterol, etc.)			
ALLERGY/IMMUNOLOGIC: (sneezing, swelling, redness, itching, hives, lupus, etc)			

PLEASE CONTINUE ON OPPOSITE SIDE OF PAGE.............

FAMILY HISTORY:

Are there any members of your immediate family (blood relatives) who have/had these diseases?

Disease/Condition:	Family Member				Disease/Condition:	Family Member			
Lazy Eye	Mother	Father	Sibling	Grandparent	Heart Disease	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent	Hypertension	Mother	Father	Sibling	Grandparent
Blindness	Mother	Father	Sibling	Grandparent	Macular Degeneration	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent	Retinal Disorders	Mother	Father	Sibling	Grandparent
Cataracts	Mother	Father	Sibling	Grandparent	Stroke	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent	Thyroid Disease	Mother	Father	Sibling	Grandparent
Glaucoma	Mother	Father	Sibling	Grandparent	Other Heritable Disease ______				

SOCIAL HISTORY: ☐ Does NOT Apply

Have you ever been diagnosed with MRSA? YES NO

Do you Smoke? YES NO How many packs daily: _____ How many years: _____ ☐ Quit

Do you consume any alcohol? YES NO Amount: ______ Frequency: ______

Do you use illegal drugs? YES NO If yes, type/amount/how long: ______

Do you drive? YES NO If yes, do you have visual difficulty when driving? YES NO Describe: ______

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphillis

CURRENT MEDICATIONS: ☐ NONE

Please include ALL: Prescription, Over the Counter, Vitamins, Minerals, Herbs, Supplements, Eye Drops, Eye Vitamins

NAME OF MEDICATION	DOSAGE	DIRECTION

MEDICATION ALLERGIES: ☐ NONE ______

PAST EYE HISTORY: ☐ NONE

CONDITION/DIAGNOSIS	PROCEDURE/SURGERY	EYE	DATE

PAST HISTORY OF ILLNESS AND/OR OPERATIONS: ☐ NONE

CONDITION/DIAGNOSIS	PROCEDURE/SURGERY	DATE

Physician's Signature: ______ **Date:** ______